Nova Scotia Provincial Health Council

Annual Report

FOR THE FISCAL YEAR ENDING MARCH 31, 2003

Provincial Health Council

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Provincial Health Council

Prepared by

Provincial Health Council
Suite 301, 1888 Brunswick Street
Halifax, Nova Scotia B3J 3P7

Tel: (902) 424-1639
Toll-free: 1 800 854-0815
Fax: (902) 424-0402

Web site: www.healthcouncil.ns.ca

To Her Honour
The Honourable Myra A. Freeman
Lieutenant Governor of Nova Scotia

Madam:

I have the honour to submit the annual report of the Provincial Health Council for the year ending March 31, 2003.

Respectfully submitted,

Jane Purves
Minister of Health

The Honourable Jane Purves
Minister of Health
Province of Nova Scotia

Madam:

On behalf of the Provincial Health Council, I have the honour to present you with the seventh annual report of the Provincial Health Council.

This report is for the period of April 1, 2002, to March 31, 2003, and is submitted as required in Section 13(1) of the Health Council Act, 1990.

Respectfully submitted,

Catherine A. Randall
Chairperson

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Message from the Chair

Fellow Nova Scotians:

As it has been with health care in this province, so has it been with the Provincial Health Council: a year of change and challenge. The council has had three Chairs in the period of a year, a major changeover in our staff, and the number of government appointments to council at 7 out of a possible 12.

However, because of the personal commitment of council members, including some whose terms have expired yet continue to contribute, we continue to do the work of council. As the report will indicate, the council has faced the changes and challenges and moved forward with very significant results.

As you may be aware from the message of the previous Chair in last year's report, the council made the decision to develop indicators around the broader determinants of health. This approach will allow us to look at the impact of these determinants in the context of the health status of Nova Scotians.

This has been a significant undertaking and a great learning experience for most of us. With the invaluable support of our staff, consultant Victor Maddalena, and a significant contribution by interested Nova Scotians, we are moving ahead with our work, which we believe upon completion may put us on the leading edge of such indicator development and reporting of health status. The names and the affiliations of the individuals who have contributed to the work are listed in the individual committee reports included in the annual report. To all we say thank you!

The work of indicator development has taken much of our time, however, as this report will inform you, we have undertaken a number of other successful initiatives. As I previously stated, the past year has been a year of changes and challenges. Challenge and change will continue into the foreseeable future, but we believe change and challenge need not be a negative. We look forward to future opportunities to have a positive impact on the health status of Nova Scotians. We also look forward to opportunities to partner with Nova Scotians, government officials, and stakeholders to assist us with our vision of "Healthy Nova Scotians living in healthy communities."

Sincerely,

CA Randall

Catherine Randall
Chairperson

Message from the Executive Director

Dear Reader:

We are pleased to present this, the seventh Annual Report of the Nova Scotia Provincial Health Council.

Despite a turnover of two-thirds of its staff, the work of the council has continued on. As well as its work on the determinants of health, council has participated in a variety of other initiatives with the citizens of Nova Scotia. We have been a part of Smoke Free Nova Scotia, working toward the passage of 100% smoke free public places legislation in our various municipalities. We applaud those municipalities that have taken this important step toward protecting the health of the residents of and visitors to those communities.

Along with many other Nova Scotians, representatives of the council have been involved in the preparation of the Chronic Disease Prevention Strategy, which will be submitted to the Department of Health in the fall of 2003. This will be a big step forward for the province in helping Nova Scotians make healthy choices and lead healthier lives.

The Healthy Communities Network is another activity council has encouraged, supported, and endorsed. This network will help communities in Nova Scotia build healthier places to live, work, and play. It provides a place for Nova Scotians to celebrate their success stories and share information about programmes and services that help to build healthier communities.

With our participation in these and many other initiatives the Provincial Health Council continues to work toward its vision of "Healthy Nova Scotians living in healthy communities."

Sincerely,

John R. Dow

John R. Dow
Executive Director

About the Provincial Health Council

Role and Mandate

The role and mandate of the Provincial Health Council are described in the Health Council Act as follows:

Duties of Council

5 The duties of the Council are to advise the Governor in Council, through the Minister, in the development of a comprehensive health policy, comprising health goals and objectives and in setting the overall direction of the health care system in the Province. 1990, c. 13, s. 5.

Manner of performing duties

6 In carrying out its duties, the Council shall

(a) invite community organizations, health care providers, consumers and individual members of the general public to provide advice on health issues under review by the Council through methods including public symposia, hearings and distribution of briefs and discussion papers;

(b) provide to the Governor in Council a balanced and informed view of the health care system;

(c) review particular issues referred to the Council by the Governor in Council, through the Minister, and advise the Governor in Council on those issues;

(d) increase public awareness and knowledge of health issues, including population health status, the cost of the health care system and personal responsibility to improve health;

(e) enhance the awareness of Government of emerging health issues from the public viewpoint. 1990, c. 13, s. 6.

Vision

Nova Scotians will be healthy and live in healthy communities as a result of a system that addresses the determinants of health and is accessible, portable, comprehensive, universal, publicly administered, accountable, transparent, and affordable.

"HEALTHY NOVA SCOTIANS LIVING IN HEALTHY COMMUNITIES"

Mission

The Provincial Health Council

- listens and responds to Nova Scotians
- supports the public's participation in health matters by providing them with information and opportunities
- guides and monitors government decision making on all aspects of healthy public policy

- promotes the use of the Nova Scotia Health Goals as an essential tool to achieve health and well-being for Nova Scotians and their communities

Core Functions

The Provincial Health Council accepts the following as core functions for both the activities of the council as a whole and the activities of its various committees:

1. increasing public awareness
2. inviting advice from the public
3. reviewing and researching issues
4. providing advice to the government

Structure

Appointed Council Members: The council comprises 12 volunteers from across the province who are appointed by the government. These volunteers serve as individuals representing Nova Scotians and do not represent any professional, organisational, political, or special interest group. There is no honorarium for service on the council.

Ex-officio Council Members: The council also has three ex-officio members—the Deputy Minister of Health, the Associate Deputy Minister of Health, and the Executive Director of the council.

To date, 20 people, 13 women and 7 men, have been appointed to the council. Nine members were from the Halifax Regional Municipality, 2 from the Annapolis Valley, 2 from the South Shore, 3 from Cape Breton, and 4 from northern Nova Scotia. Twelve members have been employed in health-related fields.

September 2002 saw the expiration of terms for Casey Mooy, Tom Bird, Leona Brown, and Vivian Farrell. Casey Mooy, Tom Bird, and Vivian Farrell continue to serve on the council until replacements are named.

January 2003 saw the resignation of Quenta Tynes from the council.

From April 2002 to March 2003 the council met in Halifax at least once a month. Appendix C lists the council meetings.

As of 31 March 2003 there are five vacancies on the council.

Committees: The council can strike various committees to assist it in its work. Following the strategic planning process over the summer of 2001, the council decided to create a committee structure to deal with the determinants of health and the health goals as working groups, to continue a communications committee, and to create a nominating committee.

Staff: The year ending 31 March 2003 saw several staff changes. Gordon W. Walsh left the council in September 2002 to accept a position with Cancer Care Nova Scotia. Darcene T. Tannis transferred to the Legal Division of the Department of Health in January 2003. Victor Maddalena continued to provide part-time research support to the several initiatives under way. Beth Rajnovich has provided temporary secretarial support to the council since mid-February 2003.

Budget

The council had an operating budget of $360,000 for 2002–03. See Appendix A for a financial statement.

Appointment Process

The Province of Nova Scotia's appointment process for government agencies, boards, and commissions follows. This process is used to fill Provincial Health Council vacancies as they occur.

Step 1 **Public call for nominations**

An advertisement listing all the openings on agencies, boards, and commissions for the next six months appears in the provincial newspapers in April and October of each year. As one-third of the Provincial Health Council terms expire the 30th of September each year, the main advertisement for members will appear in April of each year.

Step 2 **Applications are accepted by the Executive Council Office**

Each advertisement lists a closing date for the application process. Applications must be sent to the

Executive Council Office
One Government Place, 6th Floor
1700 Granville Street
PO Box 2125
Halifax, NS B3J 3B7

Step 3 **Applications are forwarded to an external screening panel**

Each government department has an external screening panel to review applications for all agencies, boards, and commissions that are attached to that government department. This screening panel reviews all applications to determine which candidates are qualified to sit on the agency, board, or commission for which they have applied.

Step 4 **Applications from qualified candidates are forwarded to the office of the Minister**

Step 5 **The Minister forwards recommendations to Cabinet**

Step 6 **Cabinet forwards their recommendations to the Human Resources Committee of the House of Assembly**

Step 7 **The appointments are signed by the Lieutenant Governor and announced**

Biographies

Current Members

TERM EXPIRING 28 SEPTEMBER 2003

Dr. Mahmood Naqvi

Dr. Naqvi has 30 years' experience in health care, which includes surgical practice and hospital administration. He was founder and co-chair of the Cape Breton Regional Hospital Foundation, which led to the establishment of the Cape Breton Regional Hospital. Upon his retirement, Dr. Naqvi became Medical Director of the Cape Breton Healthcare Complex. He has an array of professional and individual credentials, licences, and awards and has been honoured by the Medical Society of Nova Scotia and the Government of Nova Scotia.

Catherine Randall, Chair

Catherine has many years' experience in health care, beginning with Queen Mary's Veterans Hospital in Montreal, Quebec, and later working for Victoria General Hospital in Halifax and Queen's General Hospital in Liverpool, as well as the Women's Clinic, and Keddy's Nursing Manor and St. Vincent's Guest Home in Halifax. Catherine served on the Task Force on Nursing, the Minister's Action Committee on Health System Reform (Blueprint Committee), and the Minister's Task Force on Regionalization. She served as President for the Nova Scotia Certified Nursing Assistant Association and was Nova Scotia Director for the Canadian Association of Practical Nurses/Nursing Assistants.

Mildred Noiles

Mildred has several years' experience as a nurse, beginning with Douglas Hospital in Verdun, PQ, Sunset Adult Residential Centre in Pugwash, and Highland View Regional Hospital in Amherst. Mildred has a vast experience working with health organizations, including the Cumberland County Victim Support Program, the Northern Regional Community Health Board, and the Nova Scotia Task Force on Nursing. She has received extensive education in health matters such as suicide intervention; drug and alcohol abuse; abuse of the elderly; and caring, treatment, and management of persons with AIDS.

Harry Churchill

Harry is retired after spending over 30 years in health administration. His last position was the Executive Director of the Cancer Treatment and Research Foundation of Nova Scotia. During his career, he served as Nova Scotia Director on the Board of the Canadian College of Health Service Executives and as chair of the Nova Scotia Chapter. Harry was a member of the Nova Scotia Home Care Advisory Council and served on the planning committee for "The Lodge that Gives," operated by the Canadian Cancer Society, Nova Scotia Division. Harry served as vice-president and treasurer of the Nova Scotia Division of the Kidney Foundation of Canada. He is a volunteer at the IWK Hospital and is a recipient of the Queen's Silver Jubilee Medal.

TERM EXPIRING 28 SEPTEMBER 2004

Walter Proctor, Vice-Chair

Walter is a retired junior/senior school teacher and administrator. He is current chair of the Antigonish Literacy Association. He is a board member of the Antigonish Resource Centre and of the Mission Assurance Advisory Council of St. Martha's Hospital.

Brenda Sabo

Brenda has been involved in health care for approximately 20 years. Not one to remain in the same field, her experience has ranged from the Hematology Lab to nursing in both the acute care and community health settings. Since 1994 she has been involved in research (chronic illness), more recently cancer research. She is the Principal Investigator for a project to "Develop an Effective Continuing Medical Education Model for Nova Scotia Surgeons." Her present position is Professional Practice Leader, Capital District Health Authority.

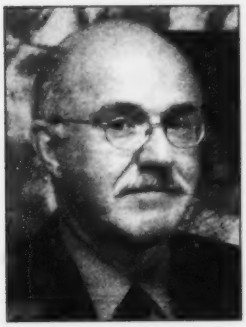
Additionally, she holds two appointments at Dalhousie University as Lecturer in the Division of Surgery, Faculty of Medicine and School of Health Sciences, Faculty of Health Professions. She teaches a first-year theory-based course in the School of Health Sciences. Brenda has published on chronic illness. Brenda has been involved as a swim official with competitive swimming for 14 years.

TERM EXPIRING 28 SEPTEMBER 2005

Casey Mooy

Casey was owner and president of Casey Mooy & Associates Limited, a consulting company that specialised in the field of financial planning, insurance, and employee benefits, which operated in the Annapolis Valley for over 30 years. He also sat as an elected councillor on Kings County Council for nine years and was a member or chair of many boards in the Valley area, including the Kings County School Board, Grand View Manor, Kings Regional Rehabilitation Centre, Nova Scotia Rehabilitation Centre, and the Kings Transit Authority. He is presently semi-retired and still involved in the financial planning field.

Ex-officio Members



Dr. Thomas Ward, Deputy Minister of Health

Dr. Ward joined the Department of Paediatrics at the University of Saskatchewan before moving to the University of Alberta, where he practised neonatology and paediactric intensive care. He served as Vice President of Medicine with St. Paul's Hospital in Vancouver, and he was the Acting President and CEO of St. Paul's Hospital and Vancouver Catholic Health Care Group.

Cheryl Doiron, Associate Deputy Minister of Health

A senior health executive with extensive experience in operations and planning, Cheryl is a New Brunswicker who previously was the regional chief operating officer for Surrey Health Services in British Columbia. Cheryl was responsible for the management of a 600-bed acute care hospital, home care nursing, community mental health clinics, and public health.

As vice president of operations and planning and business development for the Atlantic Health Sciences Corporation in New Brunswick from 1993 to 1998, Cheryl was key to the province's successful move to an integrated health care system. Her responsibilities also included managing 12 hospital and health centre sites with 4,000 employees.

The role of associate deputy was introduced in January 2000. Cheryl is responsible for program delivery including the Health Services, Community Care, Insured Services, and EHS Branch.

Staff

John Dow, Executive Director

John was appointed to the Provincial Health Council by Order-in-Council in May 1999. John began his career at Western Kings Memorial Hospital in Berwick as Supervisor. He later worked as Inservice Co-ordinator, Infection Control Officer, Administrator, Transition Co-ordinator, and Building Manager. John co-authored economics course material for an introductory health economics course at Dalhousie University and is a part-time lecturer in Dalhousie's School of Health Services Administration.

Darcene T. Tannis

Darcene served as the Provincial Health Council's Secretary from October 2001 until January 2003. Following her graduation from a Legal Secretarial Program, she was employed with Acadia University's School of Education, followed by four years serving with the Nova Scotia Community College's Central Office. She then left the field of education to gain experience in the field of new technology, serving as Executive Assistant to the President of a global dot-com company. Darcene's first experience in the field of health was initially derived from her earlier experience as an Animal Health Technologist, in addition to completion of a course in Animal Science and Phlebotomy. Her desire to contribute to positive changes in the health care field brought her to the position of serving with the Provincial Health Council.

Gordon W. Walsh

Gordon served as the Research and Statistical Officer with the Provincial Health Council from January 2002 to September 2002. Prior to joining the council, Mr. Walsh held various research and statistical positions in both the private and public sectors. His research areas of interest include alcohol and drug use and abuse, gambling, and child hunger. Currently, Mr. Walsh is midway through the completion of a MSc in Community Health and Epidemiology at Dalhousie University.

Members Whose Terms Expired During the Year

Tom Bird, Vice-Chair

A former mayor of Bridgewater, Tom's career includes 29 years as school administrator in Kings County and Lunenburg County, Nova Scotia, and Schefferville, Quebec. He served as president for the Nova Scotia Administrators' Association; Phi Delta Kappa, Acadia University Chapter; and Queens-Lunenburg School Administrators. Tom served as chairman for the Bridgewater Board of Health, Police Commission, and Lunenburg County Planning Commission.

Leona Brown

Leona was Chief Technologist and Manager of the EKG Department and Second Phase of the School of Medical Technology at Yarmouth Hospital. She is a volunteer co-ordinator with the Western Regional Health Board and is a member of the Yarmouth County Community Health Board, the Heart Health Partnership Project, the Senior Citizens Secretariat, the Volunteer Steering Committee, and the Nova Scotia Women's Institute.

Vivian Farrell, Chair

A former junior/senior high school teacher, Vivian has also been a member and President of the Childrens' Aid Society of Pictou County and a member of the former Nova Scotia Residential Centre Advisory Board in Truro. She served as chair of the Pictou District School Board and as vice-chair of the Chignecto-Central Regional School Board. Vivian also completed a three-year term as a lay member of the Nova Scotia Barrister's Society. She is presently chair of the Pictou County Continuous Learning Association.

Quenta Tynes

Quenta has several years' experience in delivering career planning and transition servicing and currently serves as Co-ordinator of Graduate Student Career Services at Dalhousie University. Quenta has served for five years on the Board of Directors for the Ward 5 Neighbourhood Centre in Halifax; two of those in the capacity of Chair. She is currently spearheading an outcomes measurement tool for the Healthy Children, Families and Seniors programs at Ward 5. Quenta was also a long-serving volunteer with the Community YMCA, Basketball Nova Scotia, and the North End Community Health Association.

Provincial Health Council Activities

The Determinants of Health

A number of factors work together to make people healthy, or not. They include:

- the social and economic environment
- the physical environment
- the person's individual characteristics and behaviours.

These factors are called the **determinants of health**.

The determinants of health do not exist in isolation from one another. Rather, they work together in a complex system. What *is* clear, though, is that people's circumstances affect their health and well-being. For example, research shows that living and working conditions have a greater impact on people's health than health care. Things like housing, income, social support, work stress, and education also make a big difference in how long people live and the quality of their lives.

It is important to consider all of these factors when thinking about health. Eating good food, exercising, or visiting the doctor are not the only things that make people healthy; it is far more complicated than that. We need to look at the context of people's lives and not simply blame them for having poor health or credit them for having good health. Many of the determinants of health are not directly under a person's control.

The following 12 items are generally accepted by most health organisations around the world as the determinants of health, and these have been adopted by the Provincial Health Council.

Income and Social Status

Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies that are prosperous and have an equitable distribution of wealth.

Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But the effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally result in more control and discretion. The biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.

There is strong and growing evidence that higher socio-economic status is associated with better health. In fact, this factor seems to be the most important determinant of health.

Social Support Networks

Support from families, friends, and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances.

The caring and respect that occur in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems.

Education

Health status improves with level of education.

Education is closely tied to socio-economic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.

Employment and Working Conditions

Unemployment, underemployment, and stressful or unsafe work are associated with poorer health.

People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

Social Environment

The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province, or country. It is reflected in the institutions, organisations, and informal giving practices that people create to share resources and build attachments with others.

The array of values and norms of a society influences in varying ways the health and well-being of individuals and populations.

In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health.

A healthy lifestyle can be thought of as a broad description of people's behaviour in three interrelated dimensions: individuals; individuals within their social environments (e.g., family, peers, community, workplace); and the relation between individuals and their social environment. Interventions to improve health through lifestyle choices can use comprehensive approaches that address health as a social or community (i.e., shared) issue.

Social or community responses can add resources to an individual's repertoire of strategies to cope with changes and foster health.

Physical Environment

The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food, and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness, and gastrointestinal ailments.

In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.

Personal Health Practices and Coping Skills

Personal health practices and coping skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges and develop self-reliance, and solve problems and make choices that enhance health.

Definitions of lifestyle include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life choices are greatly influenced by the socio-economic environments in which people live, learn, work, and play.

These influences affect lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible.

Healthy Child Development

New evidence on the effects of early experiences on brain development, school readiness, and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional, and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic make-up, and access to dental and medical care.

Biology and Genetic Endowment

The basic biology and organic make-up of the human body are a fundamental determinant of health.

Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.

Health Services Available

Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function, contribute to population health. The health services continuum of care includes treatment and secondary prevention.

Gender

Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power, and influence that society ascribes to the two sexes on a differential basis.

"Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.

Culture

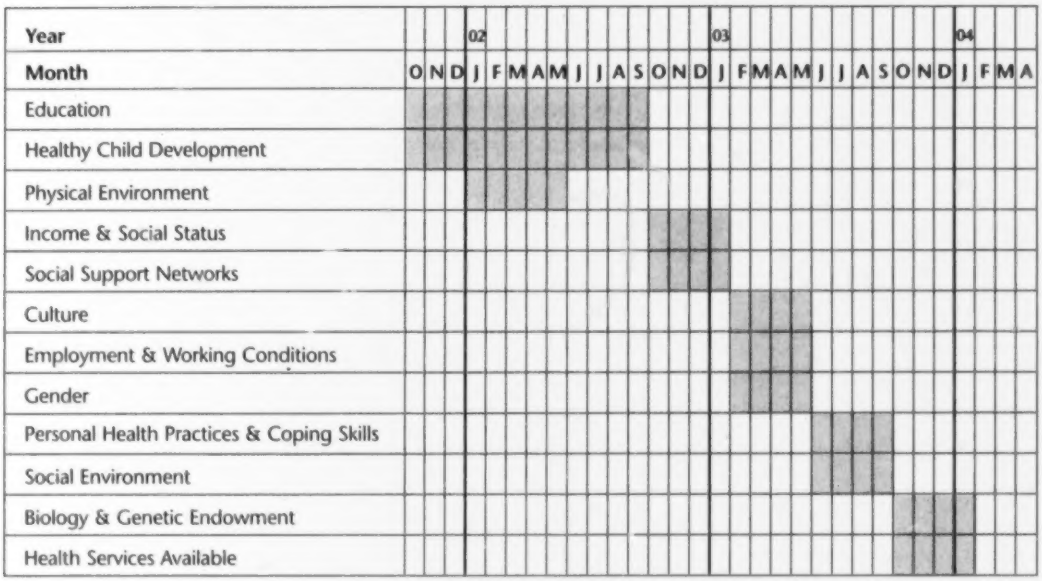
Some persons or groups may face additional health risks due to a socio-economic environment, that is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalisation, stigmatisation, loss or devaluation of language and culture, and lack of access to culturally appropriate health care and services.

Life Cycle Review

The council has decided to develop a reporting mechanism based on the determinants of health in order to talk to Nova Scotians and their policy makers about the health status of Nova Scotians and how we can improve the health of the population of Nova Scotia. To this end, the council has decided to publish an annual report on the health of Nova Scotians. A committee was struck to develop the format for this report.

The Life Cycle Review Committee has met seven times and has recommended to council to adopt a life cycle review process. The report will be developed using four stages of the life cycle—childhood and adolescence (birth to 19), young adulthood (20 to 45), mature adulthood (45 to 65), and seniors (over 65). In each of four years, a report dealing with one of the stages will be released. The fifth year will see the release of a summary report covering issues that transcend the life cycle and are not dealt with in one of the previous four reports.

Committees are preparing indicators for each of the 12 determinants, and these indicators will be used in the writing of the health status reports. The committees include members of the council, staff, representatives from related organisations, and members of the public. Here is the time line the council has adopted for the development of these indicators and the release of the first report.



Each committee had the following terms of reference with appropriate variations.

To present recommendations to the Provincial Health Council, which can be used to advise government in the development of a comprehensive health policy, on alternatives to be considered in the areas of:

A. (In this area each committee develops the specific areas it wishes to address.

B. Refer to following pages for specific areas addressed by each of the committees.)

C.

D.

E.

In the development of these recommendations, the committee must follow the core functions:

- Increasing Public Awareness
- Inviting Advice
- Issues Review and Research
- Providing Advice

The recommendations should also include a method to monitor and evaluate each of the alternatives presented.

Membership of the committee should comprise no more than eight people, with at least two members from the council. The balance should comprise people interested in _____ in Nova Scotia.

Monthly reports to be made to the council on committee activities. Formal recommendations to the council should be submitted to the council members prior to the meeting on which action is requested.

The reports of each of the committees will be dealt with in the order in which the work was completed and a final report submitted to council.

Physical Environment

The following individuals served as members of the Physical Environment Committee:

Harry Churchill (Committee Chair), Board Member, Provincial Health Council

Tom Bird, Board Member and Vice-Chair, Provincial Health Council

John Dow, Executive Director, Provincial Health Council

Vivian Farrell, Board Member and Chair, Provincial Health Council.

Barbara Hart, Volunteer and Past-Chair, Provincial Health Council

Peggy Hope-Simpson, Community Volunteer (EKM Community Health Centre)

Bob Langdon, Nova Scotia Department of Environment and Labour

Murray MacGray, Nova Scotia Technology and Science Secretariat

Alan Ruffman, Community Volunteer (GeoMarine Associates)

Victor Maddalena, Researcher, Provincial Health Council

The committee met a total of seven times and recommended that the following indicators be used to evaluate the physical environment in the health status report. The report was adopted by council on 2 May 2002.

Air Quality Indicators

PM 2.5

Definition PM 2.5 is fine particulate matter that is 2.5 microns in diameter or smaller (about the size of a single grain of flour). PM 2.5 levels of 25 micrograms per cubic metre have demonstrable health effects, although it is recognized that adverse health effects are occurring at even lower levels.

Ground-Level Ozone

Definition Ground-level ozone (O_3) is an invisible gas that is naturally produced in the atmosphere. Increased concentrations of nitrogen oxides and volatile organic compounds increase the rate of ozone formation, especially in the presence of sunlight. The currently acceptable level of ozone is 82 ppb (parts per billion), however, there is no known lower-limit threshold. Ground-level ozone is more commonly known as one of the components of smog, and higher concentrations are more prevalent in the summer.

Sulphur Dioxide (SO_2)

Definition Sulphur dioxide belongs to the family of gases called sulphur oxides. These gases are formed when fuel containing sulphur (mainly coal and oil) is burned, and during metal smelting, and in other industrial processes.

Number of Admissions to Emergency Rooms for Acute Asthma Attacks (Adult and Children)

Definition This indicator is the total number of admissions to hospitals for acute asthma attacks for a one-year period. Data is separated based on age.

Anti-Smoking Initiatives (Provincial Legislation, Municipal By-Laws, and Enforcement)

Definition This indicator is the number of provincial laws and municipal by-laws (and enforcement) that mandate "no smoking" in public areas.

Greenhouse Gas Emissions

Definition Total greenhouse gas emissions measured in megatons of carbon dioxide equivalents.

Water Quality Indicators

Water Testing (Municipal and Registered Drinking Water Supplies)

Definition Municipal water sources and registered drinking water supplies are required to maintain statistics on their water testing and treatment. Testing for bacteria, biological material, and chemical and other pollutants is required. Where there are abnormal results, this information must be reported to the Department of Environment and Labour, and appropriate corrective actions must be initiated. While there is no mandatory testing for private wells, the Department of the Environment and Labour encourages regular testing.

Boil-Water Advisories

Definition This indicator is a measure of the number of boil-water advisories in the province at a given point in time. Boil-water advisories are communicated through the media and are used to notify the public that water is unsafe for human consumption because of microbiological contamination.

Land Quality Indicators

Waste Management

Definition Nova Scotia has established four solid waste resource management strategy indicators. These include number of disposal sites, diversion of solid waste from disposal sites, number of kilograms of waste produced per capita, and percentage of organic waste being composted.

Land in Protected Areas

Definition This indicator is the areas protected by statute, expressed as a percentage of Nova Scotia's total landmass. The classification system adopted by the International Union for Conservation of Nature (IUCN) standards is used to identify areas to be included as "protected." In Nova Scotia, protected areas include national parks, provincial parks, wilderness areas, nature reserves, ecological reserves, and protected areas as defined by the Environment Act.

Other Indicators

Ultraviolet Index

Definition The UV Index provides a daily forecast of the expected risk of overexposure to the sun. The Index predicts UV intensity levels on a scale of 0 to 10+, where 0 indicates a minimal risk of overexposure and 10+ means a very high risk. Calculated on a next-day basis for dozens of cities across Canada, the UV Index takes into account clouds and other local conditions that affect the amount of UV radiation reaching the ground in different parts of the country.

Ultraviolet radiation is directly affected by the ozone layer in the atmosphere. The ozone layer forms a thin shield in the upper atmosphere, protecting life on Earth from the sun's ultraviolet (UV) rays. Depletion of the ozone layer results in increased UV radiation reaching the Earth's surface, which in turn can lead to a greater chance of overexposure to UV radiation and the related health effects of skin cancer, cataracts, and immune suppression.

Ozone is a naturally occurring gas that is found in two layers of the atmosphere. In the layer surrounding the Earth's surface—the troposphere—ground-level or "bad" ozone is an air pollutant that is a key ingredient of urban smog. The troposphere extends up to the stratosphere, which is where "good" ozone protects life on Earth by absorbing some of the sun's UV rays. Stratospheric ozone is most concentrated between 10 km and 50 km (6 and 30 miles) above the Earth's surface.

Ocean Habitat in Protected Areas

Definition The percentage of ocean area in Nova Scotia's jurisdiction that are protected under Federal or Provincial laws.

Education and Healthy Child Development

The following individuals served as members of the combined Education and Healthy Child Development Committee:

Tom Bird (Committee Chair), Board Member, Provincial Health Council

Suzanne Brown, Beechville-Lakeside-Timberlea Teen Health Centre

Heather Christian, Nova Scotia Department of Health

Michael Colborne, Nova Scotia Provincial Library

John Dow, Executive Director, Provincial Health Council

Barbara Hart, Ex-Chair, Provincial Health Council

Philip Hochman, Municipality of the District of Guysborough

Vivian Farrell, Board Member and Chair, Provincial Health Council

Marg Forbes, South West Regional School Board

Merle MacDonald, Acadia University/Mount Saint Vincent University

Brenda Montgomery, Health Care Consultant

Mildred Noiles, Provincial Health Council

Bob Quigly, Halifax Regional Parks and Recreation Services

Elizabeth Semple, North Shore Community Health Board

Gordon Walsh, Research and Statistical Officer, Provincial Health Council

Dr. Deborah Kiceniuk and Naomi Mensink both played an important role in the early stages of the committee's work.

The council decided to convert the already existing education committee into a committee to develop indicators in the two areas of education and healthy child development. The combined committee met a total of 12 times, and the two reports were adopted by council on 5 September 2002.

Education

Indicators

Education Profile of the Population

Definition This indicator measures the highest level of education completed among population aged 15 and older.

High School Graduation Rate

Definition Graduation rates are computed using a cohort method. This method relates the number of high school graduates in a given year to the number of students enrolled in grade 9 three years earlier.

University Participation Rate

Definition University participation rates are defined as the percentage of high school graduates that enrol in university either full-time or part-time in the first year following graduation.

Student Academic Assessment Results

Definition The National School Achievement Indicators Program (SAIP) is a national assessment that measures the academic achievements of a sample of 13- and 16-year-old students nation-wide. Both age groups write components of the same test, and assessment results are presented as the proportion of 13-year-old students that would achieve level 2 and the proportion of 16-year-old students that would achieve level 3. SAIP developers anticipated that the majority of students in each age group would meet the specified level.

Mobility of Post-secondary Graduates

Definition Graduate mobility refers to the percentage of graduates leaving Nova Scotia following graduation from post-secondary institutions.

Student/Educator Ratio

Definition The student-educator ratio is the total student enrolment divided by the number of educators in full-time equivalencies. Educators can be classified as either school-based (e.g., classroom teachers, guidance counsellors, special education teachers, principals, and vice principals) and non-school-based (e.g., subject/curriculum consultants, co-ordinators/supervisors, psychologists, superintendents, assistant superintendents).

Employer-sponsored Education and Participation Rate

Definition The employer-sponsored education and training participation rate is the percentage of employed adults aged 17 and older that participated in any form of employer-sponsored education and training in the past 12 months. Students between the ages of 17 and 24 years who are enrolled in full-time, non-employer-sponsored studies/training are excluded.

Literacy Levels

Definition This indicator measures the proportion of Nova Scotian adults aged 16 and older with minimum literacy skills. Literacy is defined as the "ability of adults to use written information to function in society, to achieve their goals and to develop their knowledge and potential." It is typically measured on a five-level continuum with 1 being the lowest level of literacy and 5 being the highest.

Curriculum — Percentage of Curriculum Dedicated to Health

Definition This is the percentage of overall instructional time that is dedicated to health and health-related issues (e.g., physical education, personal development, relationships).

Proportion of Schools with Youth Drop-in Health Centres

Definition This is the proportion of schools with on-site youth drop-in health centres.

Healthy Child Development

Indicators

Proportion of New Mothers Attending Prenatal Courses

Definition Number of first time mothers that completed a prenatal course prior to their child's birth in relation to the total number of first time mothers.

At-Risk Birthweight

Definition Low Birthweight: Birthweights below 2500 grams

High Birthweight: Birthweights greater than 4000 grams

Infant Mortality Rate

Definition Ratio of the number of deaths of children under one year of age to the number of live births for a given period of time.

Breastfeeding Initiation Rate

Definition Number of mothers who initiate breastfeeding in relation to the number of live births.

Childhood Immunization Rate

Definition Percentage of children receiving immunizations against diphtheria-tetanus-pertussis (DTP), polio, hemophilus influenza type B, and measles-mumps-rubella (MMR).

Proportion of Population Living Below the Low-Income Cut-off Point

Definition Proportion of persons in low-income households, as measured by Statistics Canada's low-income cut-off, in relation to the total population of households.

Number of Children Seen in Hospital with Diabetes

Definition Number of children aged 0–19 years presenting at the hospital for diabetes.

Number of Children Seen in Hospital with Asthma

Definition Number of children aged 0–19 years presenting at the hospital for asthma.

Rate of Injuries Causing Hospitalization and Death

Definition Number of children aged 0–19 years per 100,000 who died or presented at the hospital for both unintentional and intentionally self-inflicted injuries, including unintentional injuries, motor vehicle traffic crashes, falls, suicide or self-inflicted injuries, homicides or injuries due to assault, injuries of undetermined intent, and other violence.

Proportion of Obese Children and Youth

Definition Proportion of persons aged 15–23 years with a body mass index (BMI) equal to or greater than 30.0 for males and 28.6 for females. BMI is the ratio of a person's weight and the square of their height (kg/m^2).

Mental Well-Being

Definition A 25-item scale measuring six aspects of psychological well-being, including self-esteem, balance, social involvement, sociability, self-control, and happiness.

Number of Women and Children Staying in Shelters

Definition Number of women and children receiving temporary shelter from the Transition House Association of Nova Scotia for a given period of time.

Income and Social Status

The following individuals served as members of the Income and Social Status Committee either as volunteers or as representatives of their organizations:

Quenta Tynes (Committee Chair), Board Member, Provincial Health Council

Mike Chisholm, Tax Policy Division, Department of Finance

Harry Churchill, Board Member, Provincial Health Council

John Dow, Executive Director, Provincial Health Council

Vivian Farrell, Board Member and Chair of Provincial Health Council.

Margaret Johnson, Community Volunteer

Dr. George Kephart, Population Health Research Unit, Dalhousie University

Dennis Pilkey, Department of Finance

Dianne Swinemar, Executive Director, Metro Food Bank Society

Victor Maddalena, Researcher, Provincial Health Council

The committee met a total of four times, and the council adopted its report on 6 February 2003.

The committee adopted the following definition of "income and social status."

When one refers to the term "income" it is generally understood to be the amount of money that comes into a household in the form of a weekly or monthly pay cheque. Adequate income permits the purchasing of food, shelter, clothing, health care, recreation activities, and other amenities of life. When income is not adequate to meet the needs of daily life, the health of that individual or family may be compromised. Research also indicates that income levels alone do not explain the differences in health status. There are other benefits associated with earning income, including self-esteem and autonomous decision making, social connection and a sense of belonging, and making a contribution to the community. In Western society, social worth is often measured in financial terms. Taxation is a prominent feature of democratic society that not only collects revenue for social programs, but also reflects and defines social and economic policy.

Similarly, the term "social status" generally refers to one's social position or standing in a community, and this is determined by various factors such as income level, gender, race, sexual orientation, ethnicity, type of employment, abilities or disabilities, or membership in a particular group. These factors can have an impact on health, either directly by improving or reducing one's ability to meaningfully participate in the benefits of society or indirectly, for example by improving employment opportunities.

Social status reflects a position in a social structure and is usually ranked according to power and prestige. Social status differs from the concept of social class in that it is a measure of a person's social standing or social honour in a community. Individuals who share the same social class may have very divergent status. For example, ethnic origin, gender, and age as well as their level of recognition in the community affect people's social status. While social status is statistically related to social class, it is common for individuals to have inconsistent class and status locations. Most people use both the concepts of class and status to describe the systems of social stratification (the way individuals are ranked in various hierarchies of income, wealth, authority, and power) found in societies.

Social status and social class are related but different terms. Social class usually implies a group of individuals sharing a common situation within a social structure, usually their shared place in the structure of ownership and control of the means of production, for example, the working class, or a bourgeois class—those who own and control the means of production. Social class can also refer to groups of individuals with a shared characteristic relevant in some socio-economic measurement or ranking (for example, all individuals earning over $50,000 a year). This is one of the few ways by which social class can be statistically defined. While social class is extensively used in discussing social structure, popular literature tends to rely on the term social status, which offers a more complex portrait in which individuals within a class can be seen as having quite different social situations.

The committee divided the indicators into three general groupings: Wealth and Income, Cost of Living, and Taxation.

Wealth and Income Indicators

Income and Income Support

Definition Income by source of revenue by age and gender.

Distribution of Wealth

Definition Assets and debts by gender, age, and households.

Employment Rate

Definition Full-time employment as a percentage of the population by age and gender.

Employment Security

Definition Seasonal employment and part-time employment as a percentage of population by age and gender.

Cost of Living Indicators

Housing Affordability and Accessibility

Definition Core housing need (CMHC).

Food Security and Costs

Definition a) Total number of people assisted by food banks in Nova Scotia on an annual basis.

b) Population living at or below the low-income cut-off (LICO).

Social Participation

Definition Average number of volunteer hours (per capita).

Children in the Family Context

Definition a) Percentage of children represented in the low-income cut-off (LICO).

b) Percentage of children represented in the low-income measure (LIM).

c) Percentage of Children that live in families that receive the National Child Benefit Supplement.

d) Number of children who are in the care of child welfare agencies.

Taxation Indicators

Redistributive Taxation Policies and Low-Income Tax Benefits

Definition Usage of refundable and non-refundable tax credits.

Tax Burdens

Definition Average effective tax rate by income level.

Social Support Networks

The following individuals served as members of the Social Support Networks Committee either as volunteers or as representatives of their organizations:

Walter Proctor (Committee Chair), Board Member, Provincial Health Council

Jane Cowie, Coordinator, Chebucto Links – Seniors Outreach Association

Leo Dillman, Executive Director, Nova Scotia Voluntary Planning

John Dow, Executive Director, Provincial Health Council

Vivian Farrell, Chair of Provincial Health Council

Elaine Ferguson, Executive Director, Childcare Connections

Mildred Noiles, Board Member, Provincial Health Council

Victor Maddalena, Researcher, Provincial Health Council

The committee met a total of four times and its report was adopted by council on 6 February 2003.

The committee accepted the following definition of "social support networks."

Finding a succinct, all-encompassing definition of social support networks is difficult. Social support appears to be a series of inter-connected concepts rather than a unitary phenomenon. Social support may refer to characteristics of a social system, such as patterns of roles and connections that exist between or among groups of people and the way in which these relationships have evolved. Alternatively, it may refer to characteristics and behaviours of individual people, reflecting their personality, feelings, and attitudes. Social support networks—where a network is defined as a bond or tie that exists among individuals—may also be considered more strictly as a relationship of quality between or among people.

What is known is that the presence of social support promotes well-being and that a deficiency in social support is an independent determinant of poor health status and marginalisation or exclusion from the benefits of society. Also, it is known that positive social and familial relationships help to moderate adversity. This is the "stress buffering" hypothesis; the presence of social support may work by increasing self-esteem or feelings of self-worth and the comfort of knowing that there is someone to whom one can turn in times of trouble or need.

Strong social support networks also accelerate recovery once a person is ill. It is known that people without support tend not to recover as well as those that have a support network of friends and relatives. This may occur as a result of emotional support or because the sick person has a reason to live if they feel needed and loved. The tangible effects of having someone to assist with chores of daily living such as shoveling their driveway, or shopping for groceries while they are ill, constitutes a form of practical support that also aids in recovery. In a crisis, a close network of friends or relatives with strong ties may be the most valuable in offering emotional support and tangible services to assist the individual.

There is also an indirect benefit to having a strong network of social supports. Take for example how social relationships can influence one's health-related behaviours, such as encouraging preventative practices or encouraging a person to engage in unhealthy lifestyle choices. Social networks are also means by which individuals receive feedback regarding behaviours that are part of the acceptable social milieu.

Low levels of social support can also be an effect rather than a cause, because the effects of ill health, poverty, and social exclusion tend to have the effect of reducing social contact. There is also some evidence that there may be direct biological effects as a result of positive social interactions through the release of beta-endorphins.

Social support also functions by providing friendship, love, expressions of concern, understanding, empathy and encouragement, and the reassurance of knowing someone who can provide assistance when the need arises. Social support also functions by providing instrumental or practical help, such as assistance with childcare, household help, or volunteering in general.

Indicators

Voter Participation

Definition Percentage of Nova Scotians age 18 years and older who reported voting in the last election (municipal, provincial, and national).

Charitable Donations

Definition a) Donor rate

b) Total amount of donations per capita

c) Total number of donations

Community Participation

Definition Percentage participating as member by type of organisation or group, Canadians age 15 and older. This includes work-related, sports or recreation, religious affiliation, community- or school-related, cultural, educational, hobby-related, service club, political group, and "other."

Volunteering

There are five indicators under the heading of volunteering that the Committee deemed relevant to the objectives of the social support networks theme.

Definition a) Rate of volunteering: Proportion of the population age 15 and older who report having participated in volunteer activities in the past year.

b) Hours volunteered: Total hours volunteered in Nova Scotia (with Canadian comparison.

c) Distribution of volunteer events by type of organisation.

d) Volunteer activities done directly for others, not through an organisation.

e) Dollar value and full-time equivalent of volunteer hours.

Children and Youth in Care

Definition The number of children who are in the care of child welfare authorities as a proportion of the total child population age 0 to 18.

Daycare for Children (Formal Childcare)

There are two basic types of childcare services. First, many parents choose informal, privately arranged care for their children either within their own home or at the home of caregivers, such as grandparents and other relatives, friends, babysitters, and nannies. The second category of childcare represents a more formal or structured approach. Unlike informal care, these programs are subject to provincial regulations and are inspected and monitored. Formal care is offered by childcare or daycare centres, nursery schools, and family-based daycares. Many programs for school-age children outside school hours can also be categorised as formal. For the purposes of this report, the focus will be on formal childcare services because there is no valid and reliable measures for informal caregiving of children.

Definition a) Number of subsidized daycare positions in Nova Scotia.

b) Average expenditure on childcare services per household.

c) Proportion of households that spent money on childcare services.

Suicide Rate

Definition The number of deaths due to suicide, expressed as a rate per 100,000 population.

Number of Self-Help Groups in Nova Scotia

Definition Number of self-help groups registered in the registry of the Nova Scotia Self-Help Connection.

Junior High School and High School Student Population Employed Full time or Part time

Definition Employment full-time and part-time by age group and gender.

Child Abuse or Neglect

Definition The number of confirmed reports of abuse or neglect (as defined under the Community Services Act) expressed as a rate per 1,000 population age 0 to 18.

Other Activities of the Council

Communication Committee

The following individuals served as members of the Communications Committee:

Vivian Farrell (Committee Chair), Board Member, Provincial Health Council

Tom Bird, Board Member, Provincial Health Council

Leona Brown, Board Member, Provincial Health Council

John Dow, Executive Director, Provincial Health Council

Barbara Hart

Charmaine Gaudet

Meetings were held at the call of the Chair, but generally were held every two months.

The council hired the firm of MacArthur, Thompson and Law to help the council develop a communications strategy for the next three years.

Based on the information from the audit and the communications plan, the Communications Committee has considered the priorities and the resources available and made recommendations to council for activities in the next 12 months. These needs are not to be considered the total communications plan but beginning steps. The most important focus for the Provincial Health Council is the public involvement and awareness of the council and its mandate. The council wants to increase public awareness and knowledge of health issues, including population health status, the cost of the health care system, and personal responsibility to improve health.

Based on input from the council, the Communications Committee will proceed in implementing activities that help generate public input and raise awareness. The committee recommended to council the following short-term initiatives as a beginning:

A. 1. Revise and update the website to reflect changes and to ensure that it is a useful tool and source of information for the public

   2. Develop a feedback option for the general public on the revised Provincial Health Council website.

B. Have available presentation material for any council member who wishes to make presentations to groups in their home communities in the next 12 months.

C. Develop at least four public service announcements/press releases in the next 12 months pertaining to issues of priority to the council (e.g., new smoking by-laws, impact of the Romanow Report on Nova Scotians).

D. Participate in a minimum of 12 initiatives with partners (e.g., a joint news release or public service announcement or event).

E. Develop at least two newsletters and an annual report to send to stakeholders (this could be electronic and/or by mail).

F. Initiate an evaluation process using both formal and informal means of checking the effects of the council's communications strategies. This could be done by the council researcher using a random phone survey, or by buying a couple of questions from Corporate Research's quarterly surveys.

Community Health Boards and District Health Authorities

On 9 October 2002 the members of the Provincial Health Council met with representatives of the Community Health Boards of Nova Scotia. On 13 November 2002 the members of the Provincial Health Council met with the Board Chairs and the Chief Executive Officers of the nine District Health Authorities and of the IWK Health Centre. Following presentations to familiarise themselves with each other's roles and responsibilities, two questions were posed: How can we work together? and Where do we go from here?

There is concern that there may be some duplication of work and information. The Community Health Boards do work for their individual areas and the Provincial Health Council is attempting to do the same across the province.

Meeting with the Community Health Boards and District Health Authorities gives the Health Council the opportunity to become aware of what each party is working on and to avoid having the same work done twice. Organising efficient lines of communication with each of the

organisations will ensure that information is collected in the same manner and that we are asking the same questions, thereby ensuring that the information is comparable across jurisdictions.

Meetings with the Ministers

As the Provincial Health Council has undertaken its work on the determinants of health, meetings have been arranged with the various Ministers of the Crown responsible for policy in the areas addressed by the determinants. Meetings have been held with the Minister of Environment and Labour, David Morse, Deputy Minister Kevin McNamara, and Executive Assistant Ross Christie; the Minister of Health, Jamie Muir, and Deputy Minister Tom Ward; the Minister of Community Services, Peter Christie, and Deputy Minister Marian Tyson; and the Minister of Health Promotion, Rodney MacDonald, Deputy Minister Tom Ward, and Executive Assistant Allan MacMaster.

These meetings served to update the ministers on the health status reports being developed and to engage the assistance of the government departments as the indicators are developed for the determinants.

Additional meetings will be arranged to provide feedback to the ministries as the indicator work is completed and to solicit input from other departments as we move forward on the remaining determinants.

Council would like to express its appreciation to the various government departments for their participation in the development of indicators for the determinants of health.

Partnerships

Healthy Communities Network

One of the founding members of the Nova Scotia Healthy Communities Network, the council has supported the activities of this network since its inception in February 2002. The network comprises more than 30 groups and organisations across the province. The network exists to support individuals, organisations, and communities as they work toward building healthy communities for all of Nova Scotia. The network meets four times a year in various locations throughout Nova Scotia and holds an annual conference that is open to all Nova Scotians. The focus of the conferences and the quarterly meetings is to showcase Nova Scotian success stories in community capacity building.

Additional information about the network can be found at:
<http://www.heart-health.ns.ca/hpc/hcn/index.htm>.

Chronic Disease Prevention Strategy

The Provincial Health Council has been a partner in the development of this strategy since its beginnings in October 2001. Council members and staff have participated in the steering committee and in various subcommittees, especially around health public policy and health human resources. The council eagerly awaits the acceptance and release of this strategy by the government in the fall of 2003.

A Smoke-Free Strategy for Nova Scotia

The Provincial Health Council has been active in the smoke free Nova Scotia movement since participation in a workshop in June 2000 at the Citadel in Halifax. The council made a presentation to the Law Amendments Committee of the House of Assembly after Bill 125 Smoke Free Public Places Act was introduced in the House.

Following is an excerpt from the presentation made by Vivian Farrell, Chair of the council at the time, on 13 May 2002:

> First of all, let me congratulate the government for introducing a bill designed to protect many of our citizens from a well-known health hazard. However, this piece of legislation does not go far enough. We, the Provincial Health Council, advocate a total ban and urge the government to amend this legislation to provide such a ban.
>
> In 1992, the government of Nova Scotia endorsed Nova Scotia's Health Goals. They were signed by the Premier of the day, Donald Cameron and the Minister of Health George Moody. These same goals were reaffirmed in November of 1999 by this government and signed by Premier John Hamm and Minister of Health Jamie Muir.
>
> Let me quote several pieces of these Health Goals:
>
> "We see the health of our people as a resource for the present and the future. Each of us has a role to play to protect and develop that resource. Education, particularly of our children and youth, is very important."
>
> "... we will shift our emphasis to the promotion of health and the prevention of illness, disability and premature death ..."
>
> "... to be healthy we need clean air ... as well as safe places to live, work and play. We will restore, protect and develop our environments to support health."
>
> "Ensure that all Nova Scotians have the opportunity to achieve health." " ... and other issues, make it more difficult for some people to be as healthy as others."
>
> **Exposure to second-hand smoke is a serious health risk that not only kills at least 200 NONSMOKING Nova Scotians every year but also adversely affects the efforts of thousands of other Nova Scotians to achieve health.**
>
> There is a consensus among the most reputable scientific and medical academies and government agencies including our own Department of Health on the serious health hazards of second-hand smoke or environmental tobacco smoke (ETS).
>
> **The harmful effects of second hand smoke as outlined by the Ontario Tobacco Research Unit include the following:**
>
> **Exposure to second-hand tobacco smoke causes the following diseases and conditions:**
>
> *In adults:*
>
> • Heart disease
>
> • Lung cancer
>
> • Nasal sinus cancer

In children:

- Sudden infant death syndrome
- Fetal growth impairment including low birth weight
- Bronchitis, pneumonia and other lower respiratory tract infections
- Asthma exacerbation
- Middle ear disease
- Respiratory symptoms

Exposure to second hand tobacco smoke has also been linked to other adverse health effects. The relationships may be causal. These include:

In adults:

- Stroke
- Breast cancer
- Cervical cancer
- Miscarriages

In children:

- Adverse impact on cognition and behaviour
- Decreased lung function
- Asthma induction
- Exacerbation of cystic fibrosis

At least 200 non-smoking Nova Scotians die every year from exposure to second hand smoke.

Tobacco use in Nova Scotia is our number one preventable health problem. Over 1600 Nova Scotians die each year due to tobacco related disease. This has had a profound and deep impact on families and communities across the province. The experiences of California, Massachusetts, British Columbia and other jurisdictions tell us that a dynamic mix of adequately funded tobacco control programs and public policies (including second hand tobacco smoke legislation) is required to reverse these startling statistics.

With knowledge of this kind, municipalities across North America have enacted local ordinances to protect their citizens from these health hazards. Measures restricting smoking in all public places begin with the well-documented evidence that exposure to second hand tobacco smoke should be avoided. As there is no known safe level of second hand tobacco smoke, measures such as dividing restaurants and bars into smoking and non-smoking sections simply do not protect health. Action to properly reduce exposure to second hand tobacco smoke requires completely eliminating smoking in indoor public places. Second hand tobacco smoke knows no boundaries. We also want to draw your attention to the municipalities in Nova Scotia who have already enacted by-laws that go farther than this legislation in protecting the citizens of Nova Scotia. Cape Breton Regional Municipality, the Towns of Berwick, Kentville, Wolfville and New Glasgow have passed such by-laws and they are being considered

in HRM, Inverness County and Victoria County. This should indicate to the provincial government that the people of Nova Scotia are serious about a total ban on second hand tobacco smoke in enclosed spaces.

Ventilation Does Not Remove Toxins or Prevent ETS Exposure

Expert assessments, empirical evidence, risk assessment procedures, and internationally accepted indoor air quality and ventilation standards have determined that ventilation and non-smoking sections do **not** remove the toxic constituents of tobacco smoke from the air and provide no solution to the problem of exposure to second-hand smoke.

Instead, the recommendations of expert scientific panels on ETS exposure are "*clear, consistent and unanimous—**all involuntary exposure is harmful and should be eliminated.***" The U.S. Surgeon-General has called for "*100% smoke-free environments in all public areas and workplaces, including all restaurants and bars.*"

This leads us into discussion of social justice.

Worker Exposure to ETS

Restaurant, bar and casino workers are particularly at risk from workplace exposure to second-hand smoke. In restaurants, second-hand smoke levels are twice as high as in other workplaces that do not have smoking restrictions. In bars and casinos they are 3-6 times as high. Food service workers have a 50% higher rate of lung cancer than the general population.

Excess mortality for workers in smoking lounges, bars, restaurants, casinos and bowling alleys is 15–26 times higher than the US Occupational Safety & Health Administration's "significant risk" level.

Total ban legislation would reduce second hand tobacco smoke exposure among Nova Scotians by 80%, cut cigarette consumption among smokers by 20%, and save Nova Scotia an estimated $200 million a year, $50 million in avoided health care costs and $150 million in productivity losses.

Public health efforts to regulate smoking in bars and restaurants can not focus only on the patron. Food-service workers and hospitality industry workers must be afforded the same occupational health and safety protection as other workers. For this reason, Health Canada recommends a 100% smoking ban in all workplaces.

Social justice requires that we treat all citizens equally. This is one of the other issues that legislation must address. The proposed legislation will help to protect the health of most Nova Scotians, but it ignores some Nova Scotians i.e. those that work in the hospitality industry. In a free and democratic society that believes in equality before the law, the law must not create inequalities.

Youth Possession

We, the Provincial Health Council, have several concerns about the youth possession section of this legislation. The enforceability of section 9 is questionable. We are also concerned about the messages that will be sent to the youth of this province by its inclusion in the legislation. Appended to our written submission is some background

information about this important issue. We would strongly urge you to remove section 9 from the legislation, and would also strongly encourage the government to address the issues of youth smoking through the other avenues outlined in the government's comprehensive tobacco strategy.

Council provided the Law Amendments Committee with recommendations for amendments to the legislation.

Romanow Commission Committee

The following individuals served as members of the Romanow Commission Committee:

Tom Bird (Committee Chair), Board Member, Provincial Health Council

Catherine Randall, Board Member, Provincial Health Council

Dr. Mahmood Naqvi, Board Member Provincial Health Council

Kothai Kumanan

Barbara Hart

John Dow, Executive Director, Provincial Health Council

Gordon Walsh, Researcher, Provincial Health Council

Meetings were held at the call of the chair.

In April 2001, Mr. Roy Romanow was appointed Commissioner of an inquiry into the future of Canada's publicly funded health system. The first phase of the Commission on the Future of Health Care in Canada focused on fact finding, resulting in the interim report *Shape the Future of Health Care: Interim Report* released in February 2002. The second phase of the Commission set off a dialogue with Canadians on the future of their health care system.

Along with concerned Canadians, interested stakeholders were invited to participate in the national consultation phase of the Commission. A key component of the consultation phase consisted of 18 days of open public hearings in Canada's major urban centres scheduled to run between January and May 2002. While special arrangements were made to facilitate participation among rural Canadians, the commission also provided two alternative channels for Canadians to express their views, including written submissions to the commission and a Consultations Workbook posted on the commission's website (www.healthcarecommission.ca). All inputs to the commission became part of the public record.

Recognizing the enormous importance of the Commission's mandate, the Provincial Health Council (PHC) submitted *Health for Nova Scotians: The Results of a Public Consultation Process* in October 2001. The report, based on submissions from, and open public consultations with, Nova Scotians, describes a health care system that is accessible, equitable, affordable, community based, and committed to the principles of health promotion and disease and injury prevention.

The council also participated in the public debate around access to care that the commission sponsored at Mount Saint Vincent University, submitting the document *Expectations Nova Scotians Can Have About Health and Health Care* in support of the position against the creation of a "Patient's Bill of Rights" being discussed by the commission.

This is the summary and recommendations from the submission made by council to the commission:

Summary

In summary, the Provincial Health Council recognizes that reform is necessary to ensure the long-term sustainability of a high-quality, universally acceptable, and publicly administered Canadian health care system. The Council believes that reform should include an increased role and funding for disease and injury prevention and health promotion interventions. This approach has been consistently put forward since the mid-1970's whether as a cost containment or health optimization strategy. A lack of political will and, consequently, funding to support prevention and health promotion, have relegated prevention and health promotion to the sidelines of health care. In light of current economics and the anticipated demographic shift towards an aging population, it is more critical than ever that these two barriers be dealt with. This can best be accomplished by revisiting the Canada Health Act and legislating prevention and health promotion into the principles of the act and providing long-term, dedicated, and accountable funding to support high-priority program areas. Program evaluations must also become mandatory so that best practices can be established and shared across jurisdictions. In terms of program delivery, community health centres provide the optimal framework for a "determinants of health" orientation to service delivery designed to encourage individuals and communities to take greater control of their health and well being. Co-ordinated and integrated service delivery within multidisciplinary teams of health professionals and across community agencies is more health-effective and cost-effective, two prerequisites for an improved and sustainable health care system.

Recommendations

1. Legislate prevention and health promotion initiatives into the principles of the Canada Health Act.
2. Provide dedicated prevention and health promotion funding—a portion of the health care budget that is irrevocably committed to the betterment of the health of Canadians—with a mandatory evaluation component along established guidelines.
3. Encourage individuals and communities to take greater responsibility for their health and well being by expanding the Community Health Care model and ensuring greater accountability to the local population.

Additional information including the entire text of the submission may be requested from the council office.

Appendix A: Financial Statement

Cost Elements	Budget 2002–03	Year End	% Budget Spent
Staff	**$181,400**	**$143,301.56**	**79.00%**
Salaries	$153,600	$123,109.46	80.15%
Overtime	$500	$0	0%
Benefits	$24,800	$19,257.59	77.65%
Training & Education	$2,500	$934.50	37.38%
Meeting Expenses	**$48,500**	**$38,175.94**	**78.71%**
Travel for other purposes	$6,000	$0	0%
Training & Education	$2,500	$934.50	37.38%
Boards & Commissions	$30,000	$31,618.47	105.39%
Travel to council meetings		$25,544.56	
Taxi & Parking		$2,997.43	
Accommodation		$2,074.17	
Meals		$1,005.47	
Catering	$10,000	$5,622.97	56.23%
Professional Services	**$44,500**	**$40,502.91**	**91.02%**
Communications	$35,000	$0	0%
Research Consulting	$8,500	$30,071.42	353.78%
Clerical	$1,000	$10,431.49	1043.15%
Office Expenses	**$87,100**	**$47,214.76**	**54.21%**
Printing & Stationery	$30,000	$7,470.34	24.90%
Equipment	$4,200	$1,412.73	33.64%
Supplies	$3,000	$120.00	4.00%
Telecommunications	$4,500	$4,095.28	91.01%
Postage, Freight, & Duty	$4,500	$2,045.76	45.46%
Advertising	$9,000	$2,063.20	22.92%
Rent	$26,400	$26,376.00	99.91%
Computers – Hardware	$2,500	$1,133.73	45.35%
Computers – Software	$2,000	$1,943.73	97.19%
Conferences/Gifts/Misc.	$1,000	$553.99	55.40%
Books, subscriptions	$1,000	$878.30	87.83%
Taxes	$1,600	$0	0%
Total Budget	**$360,100**	**$269,195.17**	**74.14%**

Appendix B: Health Council Act

An act to Establish a Provincial Health Council

Short Title

1 This Act may be cited as the Health Council Act, 1990, c. 13, s. 1.

Interpretation

2 In this Act,

(a) "Council" means the Provincial Health Council;

(b) "Minister" means the Minister of Health and Fitness. 1990, c. 13, s. 2.

(c) Provincial Health Council

3 The Provincial Health Council is hereby established. 1990, c. 13, s. 3.

(d) Members of Council

4 (1) The Council consists of

(a) twelve members appointed by the Governor in Council through a public appointment process from a list of names of persons nominated by the general public as a result of a call by the Governor in Council for nominations from the general public;

(b) the Deputy Minister of Health and Fitness;

(c) the Administrator of Policy and Planning in the Department of Health and Fitness; and

(d) the Executive Director of the Council.

(e) Right to vote

(2) A person who is a member of the Council by reason of holding an office referred to in clause (b), (c) or (d) of subsection (1) may not vote in the deliberations of the Council.

(f) Term of member

(3) Each member appointed to the Council pursuant to clause (a) of subsection (1) shall be appointed for a term of three years except that of the first members appointed to the Council, four shall be appointed for a term of three years, four shall be appointed for a term of two years and four shall be appointed for a term of one year.

(g) Re-appointment

(4) A person appointed pursuant to subsection (3) may be re-appointed but no person may be appointed for more than two consecutive three-year terms.

(h) Quorum

(5) A majority of the voting members of the Council constitutes a quorum.

(i) Unexpired portion of term

(6) Where a person appointed pursuant to clause (a) of subsection (1) ceases to be a member of the Council for any reason other than the expiration of that person's term of office, the Governor in Council may appoint a person for the unexpired portion of the term.

(j) Vacancy

(7) A vacancy in the membership of the Council does not impair the ability of the remaining members to act.

(k) Expenses

(8) Each member of the Council shall be reimbursed for reasonable expenses necessarily incurred by the member in connection with the work of the Council. 1990, c. 13, s. 4.

(l) Duties of Council

5 The duties of the Council are to advise the Governor in Council, through the Minister, in the development of a comprehensive health policy, comprising health goals and objectives and in setting the overall direction of the health care system in the Province. 1990, c. 13, s. 5.

Manner of performing duties

6 In carrying out its duties, the Council shall

(a) invite community organizations, health care providers, consumers and individual members of the general public to provide advice on health issues under review by the Council through methods including public symposia, hearings and distribution of briefs and discussion papers;

(b) provide to the Governor in Council a balanced and informed view of the health care system;

(c) review particular issues referred to the Council by the Governor in Council, through the Minister, and advise the Governor in Council on those issues;

(d) increase public awareness and knowledge of health issues, including population health status, the cost of the health care system and personal responsibility to improve health;

(e) enhance the awareness of Government of emerging health issues from the public viewpoint. 1990, c. 13, s. 6.

Chair

7 The Governor in Council shall appoint for such term as the Governor in Council determines a member of the council appointed pursuant to clause (a) of subsection (1) of Section 4 to chair meetings of the Council, so long as that person is a member of the Council. 1990, c. 13, s. 7.

Committees of Council

8 (1) The Council may establish committees to examine specific health issues, including health goals, ethics and health technology.

Appointment to committees

(2) The Council may appoint persons who are not members of the Council to a committee and a member of the Council shall preside over meetings of the committee.

Expenses

(3) Members of a committee shall be reimbursed for reasonable expenses necessarily incurred by them in connection with the work of the Committee. 1990, C. 13, s. 8.

Executive Director

9 The Governor in Council may, after consultation with the Council, appoint an Executive Director for the Council upon such terms and conditions, including remuneration, as is determined by the Governor in Council. 1990, c. 13, s. 9.

Personnel

10 (1) Such persons as are required for the administration of this Act shall be appointed by the Council in accordance with the Civil Service Act.

Experts

(2) Notwithstanding subsection (1), the Council may, with the approval of the Minister, engage, upon such terms and conditions, including remuneration, as the Council deems fit, the services of such professional persons, technical persons and experts to advise the Council or a committee of the Council. 1990, c. 13, s. 10.

Employees of Department of Health and Fitness

11 In carrying out its duties the Council shall, in consultation with the Deputy Minister of Health and Fitness, engage the services of employees of the Department of Health and Fitness. 1990, c. 13, s. 11.

Funds

12 Funds required by the Council to carry out its duties shall be from money appropriated for that purpose by the Legislature. 1990, c. 13, s. 12.

Annual Report

13 (1) The Council shall report to the Governor in Council from time to time through and upon the request of the Minister and shall make an annual report on the activities of the Council.

Tabling of annual report

(2) The Minister shall table the annual report of the Council in the Assembly, if the Assembly is then sitting, and if the Assembly is not sitting, within fifteen days of its next sitting. 1990, c. 13, s. 13.

Repeal

14 Chapter 196 of the Revised Statutes, 1989, the Health Councils Act, is repealed. 1990, c. 13, s. 14.

Proclamation

15 This Act comes into force on and not before such day as the Governor in Council orders and declares by proclamation. 1990, c. 13, s. 15.

Appendix C: Meetings

Council Meetings

4 April 2002
2 May 2002
6 June 2002
4 July 2002
12 September 2002
3 October 2002
7 November 2002
5 December 2002
9 January 2003
16 January 2003
6 February 2003
6 March 2003

Communications Committee

1 May 2002
5 June 2002
6 November 2002
18 November 2002
20 November 2002
3 January 2003

Nominations Committee

January 2003

Appendix D: Information and Communication

Pamphlets

The Provincial Health Council. Who we are ... Why we're here ... and How to contact us

Prepared by

Provincial Health Council

Suite 301, 1888 Brunswick Street

Halifax, Nova Scotia B3J 3P7

Tel: (902) 424-1639

Toll-Free: 1 800 854-0815

Fax: (902) 424-0402